

Psychiatry's Turbid Solution

John E. Richters, Ph.D.
National Institute of Mental Health

and

Stephen P. Hinshaw, Ph.D.
University of California at Berkeley

Richters, J. E., & Hinshaw, S. (1997). Psychiatry's turbid solution. *Clinical Psychology: Science and Practice*, 4, 276-280.

Abstract

Psychiatry's generic concept of disorder has long served an important legitimizing function for the broad array of conditions for which individuals seek mental health treatment, regardless of their presumed causes. Wakefield's proposal to restrict the mental disorder concept to only a subset of these conditions has given rise to concerns about the uncertain consequences of classifying others as non-disorders. In Bergner's recent counterproposal, this concern is masked in the form of a conspicuously overinclusive definition of mental disorder. Bergner's resistance to Wakefield's classification objective underscores an important, unmet, and often unacknowledged need within the clinical treatment community. The challenge ahead lies in finding ways to address this need without compromising the integrity of efforts to develop a more coherent concept of mental disorder.

Key words: mental disorder, psychopathology, DSM-IV, treatment, psychiatry

Psychiatry's Turbid Solution

For most of psychiatry's history the concept of mental disorder seemed like a permanently turbid solution in which clear answers to definitional questions were forever clouded by "a hodgepodge of unscientific opinions, assorted philosophies, and schools of thought" (Ludwig, 1975, p. 203). Scholars have long agreed in principle that it is necessary to balance issues of scientific fact and social values in defining the boundaries between disorder and non-disorder. For most of the 20th century, however, psychiatry's efforts to define the concept of mental disorder have been undermined by the absence of a coherent framework for guiding the necessary distinctions. Consequently, discussions about the mental disorder concept often have succumbed to the pessimistic view that judgements of fact and value are inherently fused, as if dissolved into a permanently cloudy solution of ambiguities incapable of clarification.

It was to a more hopeful image of psychiatry's turbid solution that Joseph Zubin turned almost twenty years ago in reflecting on the elusive question of how to define mental disorder. Zubin's image was one in which distinctions between fact and value had not passed into solution but would eventually settle, just as layers of homogenous sediment often separate from the fluid in which they are suspended. Because the boundaries between disorder and non-disorder must be constructed on the shifting sands of scientific knowledge and social values, definitional questions must be revisited periodically on the basis of new experiences, ideas, values, and data, much like "... clearing turbid solutions by pouring them continually from one glass to the other" (Zubin, 1978, p. 3).

Although Zubin's analogy seemed more hopeful than promising at the time, psychiatry's turbid solution has indeed begun to settle in recent years. Through advances in developmental psychopathology, neuroscience, and evolutionary biology, distinctions between fact and value have begun to separate in the once-cloudy mental disorder solution (Cicchetti & Richters, 1993; Richters & Cicchetti, 1993a, 1993b; Wakefield, 1992a, 1992b). The separation is still far from complete. But its clarifying effect has already

stimulated considerable optimism in psychiatry and psychology over the possibility that a coherent, credible, and defensible framework for discriminating between disorders and non-disorders might be finally within reach. As Zubin envisioned, psychiatry now seems poised to revisit its turbid solution with the aid of new questions, insights, and perspectives.

Wakefield's Proposal

Much of the newly emerging dialogue has been stimulated and framed by the recent writings of Jerome Wakefield. In a series of influential articles, Wakefield has argued that distinctions between scientific facts and social values can be recognized and justified through the contemporary lens of evolutionary biology. Moreover, building on a critical analysis of earlier contributions by Klein, Spitzer, and others, Wakefield has proposed an overarching, hybrid, harmful dysfunction concept of disorder for harnessing these distinctions: "A condition is a disorder if and only if (a) the condition causes some harm or deprivation of benefit to the person as judged by the standards of the person's culture ... , and (b) the condition results from the inability of some internal mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mechanism." (Wakefield, 1992b, p. 384). Although the harmful dysfunction framework defines internal mechanisms broadly to include all naturally selected functions and processes of the brain, it imposes no requirement to identify or assess them at an anatomical or physiological level (Wakefield, 1992b). Internal mechanisms may be postulated in psychological or biological terms, conceptualized at different levels of abstraction, and indexed through direct or indirect means, based on theoretical considerations.

The scientific burden of making such judgments is likely to be particularly challenging in the case of mental disorders. Identifying dysfunction-based conditions requires scientific knowledge or theory about the natural mechanisms in question and about the functions they serve. It also requires a sound theoretical basis for discriminating between conditions that stem from *capacity deficits* — or failures — of naturally

selected mechanisms, and those that stem instead from *production deficits* of intact mechanisms. Contemporary theories of developmental psychopathology often conceptualize important causal processes not in terms of specific internal mechanisms and structures, but in theoretical space — often through interactions between influences both within and outside the individual.

It remains to be seen whether and how these complexities can be incorporated into Wakefield's harmful dysfunction definition of mental disorder. At present, however, the harmful dysfunction framework provides a coherent scientific and conceptual foundation for recognizing, clarifying and grappling with the difficult issues ahead. Thus, it is the framework's heuristic power, rather than any consensus about its ultimate viability for defining mental disorders, that has stimulated renewed interest and optimism. In contrast to Szasz, who summoned psychiatry in the 1960s to answer his charge that mental illness is a myth (Szasz, 1960), Wakefield's bid is in the form of an open invitation for constructive dialogue.

Bergner's Counterproposal

In his recent contribution to the emerging dialogue, Raymond Bergner argues for rejecting Wakefield's proposal in favor of an alternative definition of mental disorder. He agrees with Wakefield about the inadequacy of the definition employed by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) and the need for an agreed-upon concept of mental disorder. Moreover, he recognizes some semblance of the separation between scientific facts and social values heralded by Wakefield. As a practical matter, however, Bergner sees too many limitations in the knowledge base to justify trying to make the kinds of judgments about internal mechanisms required by the harmful dysfunction approach. Thus, dismissing Wakefield's efforts as "... heroic, but ultimately doomed" (p. 19), Bergner argues for adopting an alternative definition of mental disorder proposed by Ossario (1985): "A person is in a pathological state or condition when there is a significant restriction on his or her ability to (a) engage in deliberate action and, equivalently, (b) to

participate in the social practices of the community” (pp. 13-14).

In Bergner’s view, the superiority of this definition accrues from two advantages over competing proposals. First, he argues that it successfully discriminates between consensus cases of psychopathology and consensus non-cases. Second, he believes that it accomplishes Wakefield’s goal of identifying individuals with functional impairments or disabilities without requiring knowledge of the specific internal mechanisms responsible. Yet, Ossario’s definition not only fails on both counts, but in rather obvious and consequential ways.

In one direction, it fails to discriminate between individuals with pathological disabilities — those stemming from dysfunctions in internal mechanisms — and disabilities stemming from nonpathological deficits in knowledge, skill, value, motivation, and sometimes even situational factors. Absent the necessary conceptual moorings, Bergner’s definition of disorder necessarily floats adrift in the same sea of ambiguities as the DSM-IV definition. The vague concept of disability on which it relies is so flexible that it can accommodate almost any problem of living for which individuals seek professional help. Consequently, Bergner’s proposal hovers dangerously close to defining mental disorder as whatever the clinician treats.

In the direction of underinclusiveness, Ossario’s definition of psychopathology excludes from the mental disorder classification conditions of suffering stemming from internal dysfunctions that do not interfere with deliberate action. This not only begs deep philosophical and psychological questions about what it means to say that an action is deliberate; it also ignores widely recognized pathological disabilities of affect and cognition that do not necessarily translate into behavioral deficits. Bergner attempts to shore up this particular weakness in Ossario’s definition by extending its boundaries to individuals who are “... personally disabled to a significant degree with respect to ... knowing what one is doing, deriving meaning or satisfaction from one’s behavior” (Bergner, p. 26). In the end, however, even the revised definition remains inadequate. Its diagnostic boundaries not only fail to improve on the DSM-

IV definition justly criticized by Bergner, but actually result in unprecedented levels of overinclusiveness.

Bergner's Proposal in Context

In light of these objections it may seem odd that we consider Bergner's proposal an especially valuable contribution to definition-of-disorder dialogue. Properly understood, however, the classification objective underlying Bergner's proposal reveals much about a hidden, undermining influence on past and present definition-of-disorder discussions. Prior to Wakefield's harmful dysfunction proposal, psychiatry's difficulties in defining an adequate concept of mental disorder appeared to stem from limitations in knowledge and theory. Looked at through the Wakefieldian lens, however, Bergner's proposal reveals evidence of the clinical treatment community's long-standing resistance to relinquishing its traditional, broadly defined, generic concept of mental disorder. To understand the reasons for this resistance and the hidden challenge it poses in the newly emerging dialogue, it is necessary first to examine the historical context of Bergner's proposal.

Psychiatry's Persistent Preference

Despite the timing and contemporary character of Bergner's proposed definition, the overinclusiveness problem to which it falls victim is an oddly familiar one. Psychiatry's prior attempts to establish a defensible concept of mental disorder also have routinely ended in definitions beset by significant, consequential, and conspicuous problems of overinclusiveness. Moreover, most weaknesses, like those in the Ossario-Bergner proposal, are not particularly complex, subtle or difficult to grasp. They can often be revealed through a straightforward consideration of diagnostic decisions that would result from employing a given definition in the general population.

In his recent review of the definition-of-disorder literature, Wakefield approached the overinclusiveness problems of commonly proposed definitions as errors in reasoning (Wakefield, 1992a; 1992b). Although this is a valuable heuristic for understanding the *consequences* of definitional

weaknesses, it does not follow that those weaknesses are caused by errors in reasoning. Moreover, it stretches credulity to believe that such simple, easily avoided errors in reasoning would be so unresponsive over the years to the corrective efforts of critics. A more coherent and serviceable interpretation in our view is that the persistence of the overinclusiveness problem stems from a long-standing preference in clinical treatment community for a broadly defined concept of disorder.

Traditionally, the concept of mental disorder has been used in the mental health community as a generic reference to the conditions for which individuals seek professional help. Only a subset of these conditions, however, are believed by most clinicians to stem from underlying dysfunctions in natural mechanisms within individuals. Others are more commonly viewed as syndromes of cognitive, emotional, and social maladjustment which, although associated with significant levels of suffering and functioning impairment, do not necessarily arise from internal dysfunctions in the strict Wakefieldian sense. In addition to marital, family, and other relationship adjustment problems, there are likely to be non-dysfunction-based forms of many conditions currently classified in the DSM-IV as major mental disorders. For much of psychiatry's history, however, the practice of referring to all such conditions as mental disorders regardless of their presumed causes served an important legitimizing function both for the activities of the profession and for the conditions themselves.

In light of this tradition, there is an obvious basis for legitimate concern about the potential consequences of adopting a more restrictive, dysfunction-based definition of mental disorder such as Wakefield's. In a dichotomous world of disorders and non-disorders what would be the fate individuals who suffer from newly defined non-disorder conditions? Would they be afforded less access to mental health treatment and services? Would they be denied third-party reimbursement for those services? Would the conditions from which they suffer receive a lower priority in research, public health, and public policy considerations?

Despite the significance of these questions, they have not been addressed in definition-of-disorder dialogue. Most discussions have focused only on issues directly relevant to the specific task of how to distinguish between dysfunction- and non-dysfunction-based conditions. Rarely has this dialogue acknowledged the existence let alone legitimacy of the sizable population of individuals who may suffer from the kinds of non-dysfunction-based conditions that would be reclassified as non-disorders. As a conceptual matter, the issues relevant to justifying and defining the dysfunction/non-dysfunction distinction are independent of those concerning its possible consequences. Thus, there has been no formal need to broaden the discussion. As a practical matter, however, this inattention and silence has reinforced not only concerns about the consequences of adopting a narrower distinction but silence about those concerns as well. Rather than risk the potential consequences of reclassifying important clinical conditions as non-disorders, many in the clinical community have chosen to defend its more traditional, broadly defined concept of disorder. Because this agenda has remained in the background, however, participants in the definition-of-disorder debate have often talked past each other at cross purposes, robbing the dialogue of coherence and undermining its constructive potential.

Reconcilable Differences?

Once this background agenda is realized, the contrast between the Wakefield and Ossario/Bergner definitions can be understood as reflecting fundamentally different classification objectives. Wakefield's definition is explicitly designed to classify as mental disorders only those conditions of suffering that stem from underlying dysfunctions or disabilities, regardless of whether individuals with those disorders seek clinical treatment. Bergner's definition, however, is more consistent with the broader classification objective of encompassing the full array of conditions — dysfunction- and non-dysfunction-based — for which individuals seek mental health treatment. Moreover, in contrast to Wakefield, Bergner is concerned primarily about the population of individuals who seek treatment.

This interpretation seems at first to contradict Bergner's own characterization of his classification objectives. For example, he begins with a discussion of the importance of a coherent concept of disorder, discusses the risks of overinclusiveness, and endorses the principle of functional impairment as a basis for discriminating between disorders and non-disorders. Even more explicitly, Bergner at one point even characterizes Wakefield's harmful dysfunction definition as a reasonable paraphrase of the Ossario definition, challenging only its practical application (p. 41). Thus, Bergner's proposal seems at on its face to share Wakefield's classification objective. On closer scrutiny, however, Bergner's proposed definition arguments cannot be reconciled with Wakefield's, and is much more consistent with the broader classification objectives of the treatment community. Once this broader objective is recognized, the coherence of Bergner's proposal comes into sharp relief.

Judged by the standards of Wakefield's objectives, Bergner's definition seems beset by significant overinclusiveness problems resulting from errors in reasoning and/or insufficient attention to detail. When evaluated against the standards of the broader objective, however, there are few problems at all. In fact, from Bergner's perspective, the Wakefield definition results in extraordinary problems of *underinclusiveness!* Bergner's definitional boundaries are actually intended to include many of the conditions considered as non-disorders by Wakefield. Unfortunately, those boundaries also inevitably result in misclassifying as mental disorders conditions that stem from non-dysfunction-based deficits in knowledge, values and motivations. From Bergner's perspective these are not only necessary risks, but acceptable as well because individuals suffering from these kinds of conditions are unlikely to seek mental health treatment. Moreover, because Bergner is concerned primarily with individuals who seek mental health treatment, he is relatively insensitive to issues of misdiagnosis that might result from applying his definition outside the clinical treatment community in the general population. This also explains why Bergner is comfortable with Ossario's vague criterion for recognizing conditions that stem from underlying disabilities or dysfunctions. Within the clinical treatment community, the mere fact that

an individual and/or his caretaker seeks help for a condition is often sufficient for approaching it therapeutically as a disability.

Discussion

By introducing his harmful dysfunction framework, Wakefield offered to pour psychiatry's partially clarified solution into a new glass for a period of constructive dialogue aimed at distinguishing between dysfunction- and non-dysfunction-based forms of suffering. Bergner appears at first to have joined the new dialogue in the service of Wakefield's goal. Properly understood, however, proposal is designed to serve a different classification objective. It is a bid to stir old sediments in the service of retaining the clinical treatment community's traditional, broadly defined concept of mental disorder. During the initial decades of the 20th century this generic use of the term 'disorder' served a useful purpose in the mental health community. This once-understandable tradition, however, has not only outlived its usefulness but now works against the very interests it once served. The coherence and credibility of scientific, public health, public policy, and clinical discourse concerning issues of mental health and illness requires a conceptually sound, defensible concept of disorder (Richters, 1996; Richters & Cicchetti, 1993a, 1993b; Wakefield, 1992a, 1992b).

Although Bergner's proposed definition should be rejected as a call to the past, it would be a terrible mistake to ignore or underestimate the legitimate clinical need from which it stems. Psychiatry's generic use of the term "disorder" has long served an important legitimizing function for the broad array of conditions for which individuals seek mental health treatment. Importantly, many of these conditions are not believed by most clinicians to arise from failures in naturally selected internal mechanisms. Therefore, a newly defined, dysfunction-based concept of mental disorder would result in reclassifying these conditions as — and assigning them to the uncertain fate of — non-disorders. In the absence of a replacement classification system that acknowledges and legitimizes the clinical, public health, and scientific importance of these conditions, there will be a natural, continuing resistance within the

mainstream clinical treatment to efforts such as Wakefield's. Moreover, until this need is acknowledged and openly addressed in the definition-of-disorder dialogue, resistance will continue to be masked in the form of conspicuously overinclusive definitional proposals such as Bergner's. The challenge ahead lies in finding ways to address the legitimate concerns underlying such proposals without sacrificing or compromising the integrity of efforts to develop a more coherent concept of mental disorder.

References

- American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed., rev.). Washington, D.C.: American Psychiatric Association
- Bergner, R. M. (in press). What is psychopathology? And so what? Clinical Psychology: Science and Practice.
- Cicchetti, D. & Richters, J. E. (1993). Developmental considerations in the investigation of conduct disorder. Development and Psychopathology, 5, 5-29.
- Ludwig, A. M. (1975). Journal of the American Medical Association, 234, 603.
- Ossario, P. (1985). Pathology. In K. Davis & T. Mitchell (eds.), Advances in descriptive psychology. (Vol. 4, pp. 151-202). Greenwich, Conn.: JAP Press.
- Richters, J. E., & Cicchetti, D. (1993a). Editorial: Toward a developmental perspective on conduct disorder. Development and Psychopathology, 5, 1-4.
- Richters, J. E. & Cicchetti, D. (1993b). Mark Twain meets DSM-III-R: Conduct disorder, development, and the concept of harmful dysfunction. Development and Psychopathology, 5, 5-29.
- Szasz, T. S. (1960). The myth of mental illness: Foundations of a theory of personal conduct. New York: Harper & Row.
- Wakefield, J. C. (1992a). Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder. Psychological Review, 99, 232-247.
- Wakefield, J. C. (1992b). The concept of mental disorder: On the boundary between biological facts and social values. American Psychologist, 47, 373-388.
- Zubin, J. (1978). But is it good for science? Clinical Psychologist, 31, 1-7.

Author Notes

The opinions expressed here are those of the authors and do not necessarily represent the position of the National Institute of Mental Health or the U.S. Department of Health and Human Services. We thank Margot Lynn Richters for her comments on an earlier draft of this paper. Requests for reprints may be sent to John Richters, National Institute of Mental Health, 5600 Fishers Lane, Room 18C-17, Rockville, Maryland 20857.